Response to commentary on 'Angiosarcoma as a Potential Consequence of Autologous Lymph Node Transplantation for Lymphoedema'

Authors reported the occurrence of angiosarcoma in a patient with lower limb primary lymphoedema. Two ALNT were practiced 7 and 14 years before angiosarcoma onset. Angiosarcoma may occur in patient with primary lymphoedema.[1–3] It is possible that angiosarcoma is fortuitous and not related to previous ALNT.

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Commentary regarding "A Multicentric Experience with Open Surgical Repair and Endovascular Exclusion of Popliteal Artery Aneurysms"

Although popliteal artery aneurysms (PAA) are the most common peripheral arterial aneurysms, their incidence is low, making meaningful observations from single center series almost impossible due to variations in presentation and anatomic features. Therefore, retrospective multicenter registry studies combining the experiences of several centers, as was performed by Pulli et al.[1] have been conducted in an attempt to identify the optimal treatment options, especially after the adoption of endovascular popliteal artery aneurysm repairs (EVPAR). The disadvantage of such studies includes the lack of a standardised protocol for data collection.

Despite the relatively low frequency of PAA, the optimal treatment requires highly individualized treatment planning, and is determined by the mode of presentation (acute vs. nonacute, severity of ischemia, symptomatic vs. asymptomatic), medical condition, functional capacity and activity level of the patient, as well as anatomic characteristics (condition of the runoff vessels in the acute and chronic setting, proximal and distal extent of the aneurysm). Pulli et al. did not make any direct comparisons between endovascular or open treated patients as they were significantly different from clinical and anatomic aspects, and their overall outcomes were excellent. The patients treated with open repair in this series were more likely to present with acute limb ischemia (ALI), including patients with the most severe (Rutherford grade 2b) ischemia, or other chronic symptoms. Unfortunately, they did not present their patency data separately in patients who presented acutely from those who were treated electively, making it harder to evaluate the outcomes following open repair and EVPAR.

Patients with PAA with ALI are particularly challenging. In a systematic review of the literature between 1990 and 2008 (895 patients with ALI, Kropman et al.[2]) there was a 14.1% amputation rate and no significant difference in amputation rates with or without thrombolysis before surgery. The authors of the current study have previously reported better outcomes following successful thrombolysis,[3] but patients with more severe ischemia are typically subjected to open repair. Thrombolysis was used only in patients who presented with grade I or IIa ischemia in the current study, which is generally the recommended approach. However, with the increased availability of hybrid rooms, and familiarity of surgeons with new thrombectomy devices (e.g. rheolytic thrombectomy), accelerated thrombolysis (e.g. power pulse thrombolysis, US-assisted thrombolysis), endovascular recanalization using a combination of these techniques with early exclusion of the thrombosis with covered stents followed by "toilet" thrombolysis is increasingly used, even in patients with advanced ischemia. This approach can reinstitute blood flow to the extremity faster than a surgical approach, especially in those with no target vessels on the initial angiogram.

Due to the risk of secondary embolism being catastrophic in patients with thrombolysis, primary bypass is preferred as the initial treatment in patients with a patent artery to the foot, especially in patients with good autologous vein. Aulivola et al.[4] reported comparable outcomes in patients with emergent and nonemergent presentations, using aggressive surgical bypass in patients with distal target vessels, and utilizing thrombolysis only in those without any identifiable target vessels. Thrombolysis is still used by many due to reports suggesting that it improves runoff vessels, while others suggest that it should be reserved for patients whose clot extends to the trifurcation vessels, with primary bypass for those with clot that is confined to the popliteal artery, as one has nothing to gain, but potentially much to lose if embolization occurs.[5]

The current report is no exception in reporting the best outcomes following surgical repair using autologous grafts, (mainly GSV), with a 48 month primary patency (PP) rate of